SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Filing at a Glance

Company: Reserve National Insurance Company

Product Name: APP-M AR (6/10)	SERFF Tr Num: RNIC-126605572	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 45586
Sub-TOI: MS08I.001 Plan A 2010	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Kyle Conrad, Brenda Ingram, Misty Anglin	Disposition Date: 05/27/2010
	Date Submitted: 05/04/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 05/27/2010	Explanation for Other Group Market Type:
	State Status Changed: 05/27/2010
Deemer Date:	Created By: Brenda Ingram
Submitted By: Brenda Ingram	Corresponding Filing Tracking Number:
Filing Description:	

May 4, 2010

Ms. Rosalind D. Minor
Certified Rate and Form Analyst
Life and Health Division

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

RE: Reserve National Insurance Company - NAIC # 68462; FEIN# 73-0661453
Form APP-M AR (6/10) – Medicare Supplement Insurance Application

Dear Ms. Minor:

We are submitting the above-referenced form, which we request you consider for approval. This is a new filing not previously submitted.

Form APP-M AR (6/10) will be used as the application for our Medicare supplement policies. This form will be used with the following forms that were previously approved by your office: (1) Questions for Applicant for Medicare Supplement Insurance, which is a supplemental application that contains all the questions required in connection with an application for a Medicare supplement policy and (2) Notice to Applicant Regarding Replacement, which contains all the required questions for replacement situations,

If this filing meets with your approval, please send us evidence thereof.

Thank you for your consideration in this matter. If there are any questions, you may contact me by telephone at (800) 874-1431, by fax at (405) 840-3426 or by e-mail at kconrad@unitrin.com.

Sincerely,

Kyle D. Conrad
Senior Vice President
and Associate Corporate Counsel

KDC:bdi

Company and Contact

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Filing Contact Information

Kyle Conrad, Vice President & Associate Corporate Counsel
6100 N. W. Grand Blvd
Oklahoma City, OK 73118

kconrad@unitrin.com

800-874-1431 [Phone] 549 [Ext]

Filing Company Information

Reserve National Insurance Company
6100 N.W. Grand Boulevard
Oklahoma City, OK 73118
(405) 848-7931 ext. 549[Phone]

CoCode: 68462
Group Code: 215
Group Name: Reserve National
FEIN Number: 73-0661453

State of Domicile: Oklahoma
Company Type: Life and Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$25.00
Retaliatory?	Yes
Fee Explanation:	Application - $25.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Reserve National Insurance Company	$25.00	05/04/2010	36216451
Reserve National Insurance Company	$25.00	05/27/2010	36857985

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	05/27/2010	05/27/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Stephanie Fowler	05/27/2010	05/27/2010	Brenda Ingram	05/27/2010	05/27/2010

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 05/27/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
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Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Supporting Document	Q-MCS (6/10)	Accepted for Informational Purposes	No
Supporting Document	RP-MCS-10	Accepted for Informational Purposes	No
Form	Medicare Supplement Insurance Application	Approved	No

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/27/2010
Submitted Date	05/27/2010
Respond By Date	06/28/2010

Dear Kyle Conrad,

This will acknowledge receipt of the captioned filing. The filing fees submitted are incorrect; the new rates under Rule 57 were effective January 1, 2010. Please submit an additional $25 for the application filing.

Please feel free to contact me if you have questions.

Sincerely,

Stephanie Fowler

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	05/27/2010
Submitted Date	05/27/2010

Dear Stephanie Fowler,

Comments:
Per your request.

Response 1

Comments: An additional $25.00 has been sent via EFT.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your consideration in this matter.

Sincerely,
Brenda Ingram, Kyle Conrad, Misty Anglin

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
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TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 05/27/2010	APP-M AR (6/10)	Application/ Enrollment Form	Medicare Supplement Insurance Application	Initial			App-M AR (6.pdf

Reserve National INSURANCE COMPANY
OKLAHOMA CITY, OKLAHOMA

MEDICARE SUPPLEMENT INSURANCE APPLICATION

FOR HOME OFFICE USE ONLY
POLICY NUMBER(S):

AGENT CODE _____
MGR CODE _____

EFFECTIVE DATE: Month | Day | Year

Applicant's Name (Print) Last	First	Initial	Sex	Date of Birth Mo.	Day	Year	Age	Height	Weight
								___ ft. ___ in.	____ lbs.

Address	City	State	Zip	Phone No.

Social Security No.	PLAN APPLIED FOR	Reg. Monthly Premium $
Medicare Card No.	Date enrolled in Medicare Part A	
E-mail Address	Date enrolled in Medicare Part B	

1. If applicable: ❑ Policy Change ❑ Conversion Details_____
2. Do you have any Medicare supplement coverage in force at the time of this application?.....Yes ❑ No ❑
3. If the answer to question 2 is "yes," do you intend to replace your current Medicare supplement coverage with the policy applied for?.....Yes ❑ No ❑
(Complete replacement form if "yes")

Applicants eligible for GUARANTEED ISSUE or OPEN ENROLLMENT are not required to answer questions 4-8.

TOBACCO USE:

4. Have you used tobacco in any form within the past 12 months?.....Yes ❑ No ❑

ELIGIBILITY QUESTIONS:

IF THE ANSWER TO ANY QUESTION IN THIS SECTION IS "YES" THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

5. Are you currently confined to a hospital, nursing facility, or any other facility regardless of type, bed confined or do you use a wheelchair or any motorized mobility device or need assistance with daily living?...Yes ❑ No ❑
6. Have you been diagnosed with, received medical advice, treatment, or surgery for or been told by a medical professional that you need treatment or surgery for the following conditions:

A. at any time for:
- i) Systemic Lupus or any connective tissue disorder, implantation of defibrillator, un-operated aneurysm, Leukemia, Hodgkin's Disease, Lymphoma or cirrhosis?.....Yes ❑ No ❑
- ii) Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy or cerebral palsy?.....Yes ❑ No ❑
- iii) Kidney failure, renal insufficiency, polycystic kidney disease, kidney disease requiring dialysis, Addison's Disease or any condition requiring an organ transplant? .....Yes ❑ No ❑
- iv) Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV)? .....Yes ❑ No ❑
- v) Diabetes that requires more than 50 units of insulin daily, uncontrolled diabetes, complications of diabetes (i.e., kidneys, eyes, nerve endings, non-healing sores) or amputation caused by any disease?Yes ❑ No ❑

B. within the past three (3) years for:
- i) Alcoholism, drug abuse, anemia requiring repeated blood transfusions or any other blood disorder?..Yes ❑ No ❑
- ii) Internal cancer, melanoma, hepatitis type B or C or disorder of the pancreas?.....Yes ❑ No ❑
- iii) Cardiomyopathy? .....Yes ❑ No ❑

C. within the past two (2) years for:
- i) Congestive heart failure, enlarged heart, stroke, transient ischemic attack (TIA), peripheral vascular disease or peripheral neuropathy?.....Yes ❑ No ❑
- ii) Any type of vascular surgery, including angioplasty, by-pass, stent placement or heart valve replacement? .....Yes ❑ No ❑
- iii) Any lung or respiratory disorder requiring the use of a nebulizer, three (3) or more medications, or oxygen therapy?.....Yes ❑ No ❑
- iv) Arthritis restricting mobility or activities of daily living, osteoporosis with fractures or Paget's Disease?.....Yes ❑ No ❑
- v) Major depression, bipolar disorder, schizophrenia or a paranoid disorder? .....Yes ❑ No ❑

(Continued next page)

D. within the past one (1) year for:

i) Heart attack, any artery blockage, heart valve disorder or uncontrolled hypertension?.Yes ❑ No ❑

ii) Pacemaker implantation?.....Yes ❑ No ❑

iii) Seizures? .....Yes ❑ No ❑

7. Within the past two (2) years have you been hospitalized more than two (2) times? .....Yes ❑ No ❑

8. Within the past one (1) year have you been advised to have surgery for cataracts, joint replacement, a heart condition or any other surgery but have not yet had such surgery? .....Yes ❑ No ❑

The applicant must also meet the Company's height/weight guidelines to be eligible for coverage.

FOR HOME OFFICE USE

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto shall form the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application shall not be considered in force until issued by the Company and the first premium paid. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. In connection with an application for insurance currently made to Reserve National Insurance Company, **I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility or insurance company or MIB, INC. ("MIB"), that has any records or knowledge of me or any of the members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I understand that (a) an investigative consumer report may be obtained as to my insurability, including, if applicable, information as to character, general reputation, personal characteristics and mode of living; (b) this information will be obtained through personal interviews with my friends, neighbors and associates; and (c) additional information as to the nature and scope of any investigation requested will be furnished to me upon my written request made within a reasonable time after this application is completed.**

I have paid to Reserve National Insurance Company the sum of $ _____which is a ❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual premium, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

If accepted by the Company the applicant requests coverage to be effective: A. ❑ Date of application, applicable only on quarterly or longer modes. B. ❑ Date of issue C. ❑ Other _____

❑ SEND POLICY TO APPLICANT OR ❑ AGENT TO DELIVER.

I acknowledge receipt of an outline of coverage for which this application is made.....❑Yes ❑No.

I am eligible for Medicare and acknowledge receipt of a "**Guide to Health Insurance for People with Medicare**".....❑ Yes ❑ No.

NOTICE: The proposed insured certifies that no person to be covered under the policy applied for is covered by Medicaid or any other Title XIX program. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Town and State where signed_____ this _____ day of _____ , _____

_____ Signature of Owner (if other than Proposed Insured)

_____ Signature of Proposed Insured/Applicant

The undersigned agent (a) represents Reserve National Insurance Company in connection with the insurance applied for; (b) will receive compensation from the Company if coverage is issued; and (c) may provide services to policyholders on behalf of the Company, subject to the Company's approval. The agent does not have authority to bind the Company.

I certifiy that I asked each question of the applicant personally and the answers have been accurately recorded hereon.

_____ Signature of Agent

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
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Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Supporting Document Schedules

Item Status: **Status Date:**

Bypassed - Item: Flesch Certification
Bypass Reason: Not Applicable
Comments:

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Please see the form schedule for the application

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: Not applicable
Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage
Bypass Reason: Not applicable
Comments:

Item Status: **Status Date:**

Satisfied - Item: Q-MCS (6/10) — Accepted for Informational Purposes — 05/27/2010

Comments:
Form previously approved
Attachment:

SERFF Tracking Number:	*RNIC-126605572*	*State:*	*Arkansas*
Filing Company:	*Reserve National Insurance Company*	*State Tracking Number:*	*45586*
Company Tracking Number:			
TOI:	*MS08I Individual Medicare Supplement - Standard Plans 2010*	*Sub-TOI:*	*MS08I.001 Plan A 2010*
Product Name:	*APP-M AR (6/10)*		
Project Name/Number:	*/*		

Q-MCS 6 10.pdf

		Item Status:	**Status Date:**
Satisfied - Item:	RP-MCS-10	Accepted for Informational Purposes	05/27/2010

Comments:

Form previously approved

Attachment:

RP-MCS-10.pdf

Reserve National
INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114

QUESTIONS FOR APPLICANT FOR MEDICARE SUPPLEMENT INSURANCE

A. Are you an "Eligible Person" (see definition on reverse side) who is applying for this policy not later than 63 days after the date of termination or disenrollment in an employee welfare benefits plan, a Medicare Advantage plan, a Medicare risk or cost plan, a health care prepayment plan, a Medicare Select plan, a Medicare HMO plan or a Medicare supplement policy? ..... Yes ❑ No ❑

If "yes":

(1) Provide details

_____

_____

(2) Furnish evidence of termination or disenrollment.

B. Are you applying for this policy not later than 63 days of the date you had any "Creditable Coverage" (see definition on reverse side) .....Yes ❑ No ❑

If "yes", provide carrier's name, type of coverage, policy number, effective date and termination date.

_____

C. Statements to Applicant:

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstance, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

D. To the best of your knowledge:

(1) (a) Did you turn 65 in the last 6 months? .....Yes ❑ No ❑

(b) Did you enroll in Medicare Part B in the last 6 months? ..... Yes ❑ No ❑

(c) If so, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program? .....Yes ❑ No ❑

[NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.] If YES:

(a) Will Medicaid pay your premiums for this Medicare supplement policy? .....Yes ❑ No ❑

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....Yes ❑ No ❑

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ___/___/___ END ___/___/___

(Continued on back)

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?.....Yes ❑ No ❑

(c) Was this your first time in this type of Medicare plan?..... Yes ❑ No ❑

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? .....Yes ❑ No ❑

(4)(a) Do you have another Medicare supplement policy in force?.....Yes ❑ No ❑

(b) If so, with what company, and what plan do you have? _____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? .....Yes ❑ No ❑

(5) Have you had coverage under any other health insurance within the past 63 days? (For example an employer, union or individual plan).....Yes ❑ No ❑

(a) If so, with what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? START ___/___/___ END ___/___/___ (If you are still covered under the other policy, leave "END" blank.)

E. Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

_____

(2) List policies sold in the past five (5) years which are no longer in force.

_____

IT IS AGREED THAT ALL STATEMENTS AND ANSWERS CONTAINED ON THIS FORM ARE FULL, COMPLETE AND TRUE AS WRITTEN AND ARE CORRECTLY RECORDED.

_____ _____

Date Signature of Proposed Insured or Applicant

I CERTIFY THAT I ASKED EACH QUESTION OF THE APPLICANT PERSONALLY AND THE ANSWERS HAVE BEEN ACCURATELY RECORDED HEREON.

_____ _____

Date Signature of Agent

AN ELIGIBLE INDIVIDUAL IS ONE WHO: (1) Enrolled under an employee welfare benefit plan that supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or **(2)** Enrolled with a Medicare Advantage organization under a Medicare Advantage plan, or he/she is age 65 or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider, and specific circumstances permit discontinuance including, but not limited to, the organization's or plan's certification is terminated, the plan is terminated within a residence area, he/she is no longer eligible due to a residence change, the organization violated a material contract provision, a material misrepresentation was made to the individual or other exceptional conditions provided by regulation; or **(3)** Enrolled with a Medicare cost contract or similar organization, a health prepayment plan or an organization under a Medicare Select policy and the enrollment ceases under the same circumstances that would permit discontinuance under the preceding item (2); or **(4)** Enrolled under a Medicare supplement policy and coverage discontinues due to the insolvency or the issuer or bankruptcy of the nonissuer organization, the issuer substantially violated a material policy provision or the issuer or agent or other entity acting on the issuer's behalf materially misrepresented the policy's provision in marketing the policy; or **(5)** Enrolled under a Medicare supplement policy and terminates enrollment, and enrolls for the first time in a Medicare Advantage plan, a Medicare cost contract, a similar organization, with a PACE provider or in a Medicare Select policy, and then that enrollment is terminated within 12 months; or **(6)** Upon first becoming eligible for benefit under Medicare Part A at age 65, enrolls in a Medicare Advantage plan, or with a PACE provider, and then disenrolls within 12 months; or **(7)** Enrolls in a Medicare Part D plan during the initial enrollment period and, at that time, had a Medicare supplement policy that covers outpatient prescription drugs and he/she terminates the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with an application for Plans A, B or F.

CREDITABLE COVERAGE IS DEFINED AS: (1) a group health plan; **(2)** health insurance coverage; **(3)** Part A or B of Medicare; **(4)** Medicaid; **(5)** CHAMPUS; **(6)** a medical care program of the Indian Health Service or of a tribal organization; **(7)** a state health benefits risk pool; **(8)** the Federal Employees Health Benefits Program; **(9)** a public health plan; **(10)** a health benefit plan under the Peace Corps Act; and **(11)** any other coverage that is considered "Creditable Coverage" under applicable law. **CREDITABLE COVERAGE DOES NOT INCLUDE: (A)** accident-only or disability income coverage, coverage issued as a supplement to liability insurance, liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics and other similar insurance under which medical care benefits are secondary or incidental to other insurance; **(B)** limited scope dental or vision benefits and long-term care, nursing home care, home health care or community-based care benefits and other similar limited benefits insurance, if provided under a separate policy; **(C)** specified disease coverage and hospital indemnity or other fixed indemnity insurance, if offered as independent, non-coordinated benefits; **(D)** Medicare supplement insurance, CHAMPUS supplement insurance or similar supplemental coverage under a group health plan, if offered as a separate policy; or **(E)** any other coverage that is not considered "Creditable Coverage" under applicable law.

Reserve National
INSURANCE COMPANY
601 East Britton Road • Oklahoma City, OK 73114

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Reserve National Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER AND AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ❑ Additional benefits.
- ❑ No change in benefits, but lower premiums.
- ❑ Fewer benefits and lower premiums.
- ❑ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❑ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

- ❑ Other. (please specify)_____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____

(Agent's Signature) (Applicant's Signature)

Reserve National Insurance Company Home Office:
601 East Britton Road
Oklahoma City, Oklahoma 73114

_____

(Date)